



LOG #
Date:

CY2022 Open Enrollment October 15 – December 7
Medicare Drug Plan Pre-Enrollment Information
SHINE Program at HESSCO (781) 784-4944, extension 254

Print Name: _____ Phone: _____ Date of Birth: _____

Address: _____

Street

City

Zip Code

Email address: _____ Marital Status: _____

Medicare #*: _____ Effective Date** of Medicare A _____ B: _____

*As it appears on your Medicare card

**As it appears on your Medicare card - Month & Year

Do you have a Medicare.gov account?

→ IF YES: Username: _____ Password: _____

→ IF NO: Please sign below to give SHINE permission to create and use a Medicare.gov account for you.

(SHINE will assign: Username, Password, & Answer to a Secret Question)

Signature: _____

Are you enrolled in any of the following supplemental insurance plans (medigaps), please check if yes:

Blue Cross/Blue Shield Medex:	<input type="checkbox"/> Bronze	<input type="checkbox"/> Sapphire	<input type="checkbox"/> Core
Health New England:	<input type="checkbox"/> Supplement 1	<input type="checkbox"/> Supplement 1A	<input type="checkbox"/> Core
United/ AARP:	<input type="checkbox"/> Supplement 1	<input type="checkbox"/> Supplement 1A	<input type="checkbox"/> Core
Fallon:	<input type="checkbox"/> Supplement 1	<input type="checkbox"/> Supplement 1A	<input type="checkbox"/> Core
Humana:	<input type="checkbox"/> Supplement 1	<input type="checkbox"/> Supplement 1A	<input type="checkbox"/> Core
Harvard Pilgrim:	<input type="checkbox"/> Supplement 1	<input type="checkbox"/> Supplement 1A	<input type="checkbox"/> Core
Tufts:	<input type="checkbox"/> Supplement 1	<input type="checkbox"/> Supplement 1A	<input type="checkbox"/> Core
<input type="checkbox"/> VA Health Plan	<input type="checkbox"/> Other _____		

Do you have a Part D Drug plan? Yes ___ No ___ If yes, name of plan _____
OR

Do you have a Medicare Advantage (PPO or HMO) with RX plan? Yes ___ No ___
If yes, name of plan _____

Do you get reduced-cost or free prescription drugs through any State or Federal Program? Yes ___ No ___
If yes, name of program: _____

Are you enrolled in Prescription Advantage? Yes ___ No ___ No, but I have recently applied ___

PLEASE LIST YOUR PRESCRIPTION DRUGS ON THE BACK SIDE OF THIS FORM

For office use only	
Medicare.gov account established <input type="checkbox"/>	Original cost
SHINE format <input type="checkbox"/>	New Cost
Counselor's Initials:	SAVINGS:

Pharmacy choice can impact your costs!

Would you change your pharmacy to save money? Yes _____ No _____

Which pharmacy do you currently use? _____

If Yes, please name specific pharmacies you would prefer to use:

Although it may not be the most cost-effective option, I only want to use mail order for my drug plan: Yes _____ No _____

Drug Name Example: <u>Metoprolol Succinate</u> <u>Novolog FlexPen</u> * AS IT APPEARS ON THE BOTTLE: IF YOU TAKE GENERIC LIST THE GENERIC NAME * DO NOT LIST VITAMINS, ASPIRIN, OR OTHER OVER THE COUNTER NON PRESCRIPTION ITEMS	Drug Strength & Dosage Example: <u>50 Mg. – one per day</u> <u>8 Pens per month</u> * WRITE TABLET or CAPSULE, VIALS, TUBES, BOTTLES (with the size of bottle) * LIST MONTHLY QUANTITIES * PLEASE ESTIMATE HOW MANY AND HOW OFTEN INSTEAD OF USING “AS NEEDED”.
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14.	

Please mail this completed form to:

**Walpole Council on Aging, Attention SHINE Counselor
60 South Street
Walpole 02081**